**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.LuminareHealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 866-280-4120 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network provider: $0 / individual or $0 / family per calendar year.<br>Out-of-network provider: Not applicable. | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | No. | You will have to meet the deductible before the plan pays for any services. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Network provider: $2,000 / individual or $4,000 / family per calendar year.<br>Out-of-network provider: Not applicable. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Penalties for failure to obtain preauthorization for services, premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |



(HHS - OMB control number: 0938-1146/Expiration date: 05/31/2026)

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See www.anthem.com/ca or call 866-280-4120 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out of Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 copay / visit | Not covered | None. |
| | Specialist visit | $30 copay / visit | Not covered | None. |
| | Preventive care / screening / immunization | $0 copay / visit | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $0 copay / test | Not covered | None. |
| | Imaging (CT/PET scans, MRIs) | $100 copay / test | Not covered | None. |

* For more information about limitations and exceptions, see the plan or policy document at www.LuminareHealth.com.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out of Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.anthem.com or call 833-768-2080 | Generic drugs (Tier 1) | Retail: $10 copay / prescription (retail) Mail order: $20 copay / prescription (mail order & Retail90) | Retail: $10 copay / prescription (retail) Mail order: $20 copay / prescription (mail order) | Female oral contraceptives (generic) have no copay for retail & mail order. Covers up to a 34 day supply (retail) or 90 day supply (mail order or Retail90). |
| | Preferred brand drugs (Tier 2) | Retail: $30 copay / prescription (retail) Mail order: $60 copay / prescription (mail order & Retail90) | Retail: $30 copay / prescription (retail) Mail order: $60 copay / prescription (mail order) | Covers up to a 34-day supply (retail prescription); 35-90 day supply (mail order prescription or Retail90). |
| | Non-preferred brand drugs (Tier 3) | Retail: $60 copay / prescription (retail) Mail order: $120 copay / prescription (mail order & Retail90) | Retail: $60 copay / prescription (retail) Mail order: $120 copay / prescription (mail order) | Covers up to a 34-day supply (retail subscription); 35-90 day supply (mail order prescription or Retail90). |
| | Specialty drugs (Tier 4) | Subject to the applicable Generic, Preferred, and Non-preferred copays listed above | Not covered | Covers up to a 34-90 day supply. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $200 copay | Not covered | Preauthorization may be required. |
| | Physician/surgeon fees | $0 copay | Not covered | None. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out of Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | $150 copay / visit | | Copay waived if admitted, including if admitted for observation. |
| | Emergency medical transportation | $0 copay | | Preauthorization is required for air ambulance and ground non-emergency. |
| | Urgent care | $30 copay / visit | | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $150 copay | Not covered | Preauthorization is required. |
| | Physician/surgeon fees | $0 copay | Not covered | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copay / visit<br>Facility: No cost sharing | Not covered | Preauthorization is required, including for residential, partial hospitalization and intensive outpatient. |
| | Inpatient services | $0 copay | Not covered | Preauthorization is required. |
| **If you are pregnant** | Office visits | $30 copay / visit | Not covered | Preauthorization is required if stay exceeds 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section.<br>Cost sharing does not apply for preventive services. Depending on the type of services, a copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | $0 copay | Not covered | |
| | Childbirth/delivery facility services | $150 copay | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out of Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | $30 copay / visit | Not covered | Preauthorization is required. Preauthorization is required for home infusion. Limited to 100 visits per calendar year. A periodic visit by either a nurse or therapist, or up to 4 hours of home health care services. |
| | Rehabilitation services | $30 copay / visit | Not covered | Limited to 52 visits per calendar year; combined with acupuncture, chiropractic, and physical therapy. Occupational therapy, speech therapy, and cardiac rehabilitation visits are not limited. This restriction does not apply in circumstances of treatment for ABA recognized therapies. |
| | Habilitation services | $30 copay / visit | Not covered | Limited to 52 visits per calendar year; combined with acupuncture, chiropractic, and physical therapy. Occupational therapy, speech therapy, and cardiac rehabilitation visits are not limited. This restriction does not apply in circumstances of treatment for ABA recognized therapies. |
| | Skilled nursing care | $0 copay | Not covered | Preauthorization is required. Limited to 100 days per calendar year. |
| | Durable medical equipment | $0 copay | Not covered | Preauthorization is required for each durable medical equipment purchase over $1,500 and durable medical equipment rental over $500 a month. |
| | Hospice services | $0 copay | Not covered | Preauthorization is required. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | None. |
| | Children's glasses | Not covered | Not covered | None. |
| | Children's dental check-up | Not covered | Not covered | None. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care (Child, Adult)
- Infertility treatment (except for diagnostic testing)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture (52 combined maximum visit with chiropractic care & physical therapy)
- Bariatric surgery
- Chiropractic care (52 combined maximum visits with acupuncture & physical therapy)
- Cochlear implant
- Hearing aids (one per ear, every 3 years)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Trustmark Health Benefits by calling 866-280-4120 or the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage?** **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards?** **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-280-4120.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-280-4120.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-280-4120.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-280-4120 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-280-4120.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-280-4120.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-280-4120.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-866-280-4120.

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$30** |
| **Hospital (facility) cost sharing** | **$150** |
| **Other copayment** | **$30** |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $180 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$240** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$30** |
| **Hospital (facility) cost sharing** | **0%** |
| **Other copayment** | **$30** |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $1,200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,220** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$30** |
| **Hospital (facility) cost sharing** | **$150** |
| **Other copayment** | **$30** |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$400** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

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| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network provider: $350 / individual or $1,400 / family per calendar year.<br>Out-of-network provider: $500 / individual or $2,000 / family per calendar year. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. The following services by a network provider: Preventive care. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Network provider: $1,600 / individual or $6,400 / family per calendar year.<br>Out-of-network provider: $5,600 / individual or $22,400 / family per calendar year.<br>Prescription drugs maximum: $5,125 / Individual or $7,300 / family per calendar year. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |



(HHS - OMB control number: 0938-1146/Expiration date: 05/31/2026)

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is not included in the out-of-pocket limit?** | Penalties for failure to obtain preauthorization for services, premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.anthem.com/ca or call 866-280-4120 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out of Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 10% coinsurance | 40% coinsurance | None. |
| | Specialist visit | 10% coinsurance | 40% coinsurance | None. |
| | Preventive care / screening / immunization | 0% coinsurance (deductible does not apply) | 40% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 40% coinsurance | None. |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 40% coinsurance | None. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out of Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.anthem.com or call 833-768-2080 | Generic drugs (Tier 1) | Retail: $10 copay / prescription (retail) Mail order: $20 copay / prescription (mail order & Retail90) | Retail: $10 copay / prescription (retail) Mail order: $20 copay / prescription (mail order) | Female oral contraceptives (generic) have no copay for retail & mail order. Covers up to a 34 day supply (retail) or 90 day supply (mail order or Retail90). |
| | Preferred brand drugs (Tier 2) | Retail: $30 copay / prescription (retail) Mail order: $60 copay / prescription (mail order & Retail90) | Retail: $30 copay / prescription (retail) Mail order: $60 copay / prescription (mail order) | Covers up to a 34-day supply (retail prescription); 35-90 day supply (mail order prescription or Retail90). |
| | Non-preferred brand drugs (Tier 3) | Retail: $60 copay / prescription (retail) Mail order: $120 copay / prescription (mail order & Retail90) | Retail: $60 copay / prescription (retail) Mail order: $120 copay / prescription (mail order) | Covers up to a 34-day supply (retail subscription); 35-90 day supply (mail order prescription or Retail90). |
| | Specialty drugs (Tier 4) | Subject to the applicable Generic, Preferred, and Non-preferred copays listed above | Not covered | Covers up to a 34-90 day supply. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 40% coinsurance | Preauthorization may be required. |
| | Physician/surgeon fees | 10% coinsurance | 40% coinsurance | None. |

* For more information about limitations and exceptions, see the plan or policy document at www.LuminareHealth.com.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out of Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | $100 copay / visit and then 10% coinsurance | | Copay waived if admitted, including if admitted for observation. |
| | Emergency medical transportation | 10% coinsurance | | Preauthorization is required for air ambulance and ground non-emergency. |
| | Urgent care | 10% coinsurance | | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 40% coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | 10% coinsurance | 40% coinsurance | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 10% coinsurance | 40% coinsurance | Preauthorization is required, including for residential, partial hospitalization and intensive outpatient. |
| | Inpatient services | 10% coinsurance | 40% coinsurance | Preauthorization is required. |
| **If you are pregnant** | Office visits | 10% coinsurance | 40% coinsurance | Preauthorization is required if stay exceeds 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section. Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance and deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 10% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 40% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out of Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance | 40% coinsurance | Preauthorization is required.<br>Preauthorization is required for home infusion.<br>A periodic visit by either a nurse or therapist, or up to 4 hours of home health care services. |
| | Rehabilitation services | 10% coinsurance | 40% coinsurance | Limited to 52 visits per calendar year for chiropractic.<br>Limited to 52 visits per calendar year for acupuncture.<br>No out-of-network provider benefits for acupuncture, chiropractic care and physical therapy. |
| | Habilitation services | 10% coinsurance | 40% coinsurance | Limited to 52 visits per calendar year for chiropractic.<br>Limited to 52 visits per calendar year for acupuncture.<br>No out-of-network provider benefits for acupuncture, chiropractic care and physical therapy. |
| | Skilled nursing care | 10% coinsurance | 40% coinsurance | Preauthorization is required.<br>Limited to 100 days per calendar year. |
| | Durable medical equipment | 10% coinsurance | 40% coinsurance | Preauthorization is required for each durable medical equipment purchase over $1,500 and durable medical equipment rental over $500 a month. |
| | Hospice services | 10% coinsurance | 40% coinsurance | Preauthorization is required. |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | None. |
| | Children's glasses | Not covered | Not covered | None. |
| | Children's dental check-up | Not covered | Not covered | None. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture – Out-of-network provider
- Chiropractic care – Out-of-network provider
- Cosmetic surgery
- Dental care (Child, Adult)
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Physical therapy – Out-of-network provider
- Routine eye care
- Routine foot Care

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture – Network provider only
- Bariatric surgery
- Chiropractic care - Network provider only
- Cochlear implant
- Hearing aids (one per ear, per year)
- Private duty nursing (outpatient only)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Trustmark Health Benefits by calling 866-280-4120 or the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage?** **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards?** **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-280-4120.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-280-4120.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-280-4120.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-280-4120 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-280-4120.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-280-4120.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-280-4120.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-866-280-4120.

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***

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## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$350** |
| **Specialist coinsurance** | **10%** |
| **Hospital (facility) coinsurance** | **10%** |
| **Other coinsurance** | **10%** |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $350 |
| Copayments | $10 |
| Coinsurance | $1,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,620** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$350** |
| **Specialist coinsurance** | **10%** |
| **Hospital (facility) coinsurance** | **10%** |
| **Other coinsurance** | **10%** |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $350 |
| Copayments | $900 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,470** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$350** |
| **Specialist coinsurance** | **10%** |
| **Hospital (facility) coinsurance** | **10%** |
| **Other coinsurance** | **10%** |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $350 |
| Copayments | $100 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$650** |

The plan would be responsible for the other costs of these EXAMPLE covered services.